IMPORTANT NOTICE for MEDICARE SAVINGS RECIPIENTS

If you want to continue to receive reimbursement for a portion of your Medicare Part B premium, you must complete this application and return it to your county department of social services. To assure full benefits, please return by March 31, 2002.

REENROLLMENT APPLICATION FOR QUALIFYING INDIVIDUALS 2

Read these instructions first. Fill out the front and back of this application completely. Read the inserted Rights and Responsibilities thoroughly. **Sign your name** on the back of the application and return it in the enclosed envelope or take it to your county department of social services. Fold it so the county's address shows through the window. Include any other information requested below with the application. **Put a stamp on the envelope**. If you have any questions or need help completing the application, call your county department of social services.

If you are acting on behalf of the person listed above, please answer all the following questions for that person and tell us your relationship to them.

1. What is your current address?_____

2. Phone number or number where you can be reached _____

3. Do you live with your spouse? _____

If yes, spouse's name _____

(If your spouse wants to apply for Medicaid or Medicare Savings Programs, he/she must complete his own application.)

4. **INCOME -- Do you or your spouse have any of the following income?**

TYPE OF INCOME	GROSS AMOUNT	HOW OFTEN RECEIVED	WHO RECEIVED IT
Your Social Security Spouse's Social Security			
Your Retirement/Pension Spouse's Retirement/Pension			
Veteran Benefit			
Rental Income			
Earned income			
Other income			

Include a copy of your most recent award letters, pay stubs, or other verification of your income when you return this application.

5. ASSETS -- Do you or your spouse have any of the following assets?

TYPE OF ASSET	Account Number	Name of Bank or Insurance Co., or location of property.	Cash or Tax Value	Amount Owed
Cash on hand				
Checking Account(s)				
Saving Account(s)				
Land/buildings (other than homesite)				
List vehicles (cars, boats, trucks, recreational, motorcycle, etc.)				
List Life Insurance policies				
List any other asset you or your spouse own and its value				

PLEASE SEND YOUR MOST RECENT BANK STATEMENT FOR ALL ACCOUNTS IN THE SAME ENVELOPE.

6. If you have a medical or health insurance policy, write the name of the company and account number:
_____

READ, SIGN, AND DATE HERE

I, the undersigned, authorize the release of any information necessary to establish Medicaid eligibility. I understand this information may include medical or non-medical information, including such collateral sources as banks, employers, and insurance companies. This authorization may be reproduced.

I certify I have read the enclosed Rights and Responsibilities.

X_____ _____
Signature Date signed

X _____ _____ _____
Representative/witness Relationship to client Date signed

DMA – 5070 (revised 10/01)